Reset

Notice of Benefit Payment

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DO NOT USE THIS SPACE

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

WID or SSN	DATE OF INJURY
EMPLOYEE (last, first, mi)	EMPLOYER
EMPLOYEE ADDRESS	
CITY STATE ZIP CODE	
INSURER CLAIM NUMBER	

☐ **THE FOLLOWING PERMANENT PARTIAL DISABILITY BENEFIT WILL BE PAID TO YOU:**

_____ % of whole body according to Minnesota Workers' Compensation Permanent Partial Disability Schedule number(s) _____

The rating is based on the attached medical report of Dr. _____ dated _____

☐ This payment is based on the preliminary rating. If your final disability rating is higher, further payments will be made.

For injuries on or after 10/01/1995 payment will be made at $ _____ per week beginning on (date) _____ for a total of _____ weeks and a total amount of $ _____

For injuries on or after 10/01/2000 a total lump sum payment of $ _____ , rather than weekly payments will be made as requested by the employee.

For injuries between 01/01/1984 and 09/30/1995 payment will be made as follows:

☐ $ _____ **Impairment compensation** will be paid in a lump sum on _____ (date).

(if you are laid off from your job for economic reasons within _____ weeks of the day your returned to work, you may be entitled to monitoring period compensation, in addition to Impairment Compensation.)

☐ **Periodic impairment compensation** or ☐ **Periodic economic recovery compensation**

of $ _____ per week beginning on _____ (date) will be paid for up to _____ weeks. If you return to work before this number of weeks, you will receive the balance due in a lump sum after working 30 days.

☐ **26 weeks economic recovery compensation** (M.S. § 176.101, subd. 3t) of $ _____

per week will be paid beginning on _____ (date).

☐ **YOUR FINAL PAYMENT OF** $ _____ **FOR** _____

BENEFITS ☐ **WAS** ☐ **WILL BE ISSUED ON** _____ **(DATE) ACCORDING TO:**

A. ☐ An award on agreement of the parties dated _____

B. ☐ A prior Notice of Benefit Payment for periodic payment of permanent partial disability dated _____

C. ☐ An administrative decision under M.S. § 176.239 dated _____

D. ☐ A judge's decision and order dated _____

INSTRUCTIONS TO EMPLOYEE

You are responsible for reviewing this form to make sure that you have been properly paid the benefits due you. YOU DO NOT NEED TO TAKE ANY ACTION IF YOU BELIEVE THAT YOU HAVE RECEIVED ALL BENEFITS DUE YOU OR THAT THE REDUCTION OF BENEFITS IS PROPER.

If you have questions about your benefits, you should first contact the claim representative whose telephone number is at the bottom of the page. Be sure to provide that person with any additional information you have to support your claim. If you still have questions, contact the Workers' Compensation Division's Benefit Management and Resolution Unit at the office nearest you.

Minnesota Department of Labor and Industry

525 Lake Avenue South, Suite 330
Duluth, MN 55802-2368
Telephone: (218) 733-7810
1-800-365-4584

443 Lafayette Road North
St. Paul, MN 55155-4301
Telephone: (651) 284-5030
1-800-342-5354

Mailing Address
Workers' Compensation Division
PO Box 64221
St. Paul, MN 55164-0221

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.

THE FOLLOWING BENEFITS HAVE BEEN PAID	FROM	THROUGH	WEEKS	RATE	*TOTAL
☐ Temporary Total Disability or ☐ Permanent Total Disability ☐ Benefit Addendum Attached					
Temporary Partial Disability					
Retraining Benefits					
Permanent Partial Disability _____% ☐ Injuries on or after 10/01/95 ☐ Impairment Compensation (injuries 01/01/1984 - 09/30/1995) ☐ Economic Recovery Compensation (injuries 01/01/1984 - 09/30/1995) ☐ _____ [part of body] (injuries before 01/01/1984)					

Attorney Fees/Expenses		Benefit Totals	
M.S. 176.081, subd. 1 & 3 Paid		*Lump sum Payment Under Award or Order	
M.S. 176.081, subd. 1 & 3 Still Withheld		Attorney Fees Reimbursed to Employee (M.S. 176.081, subd. 7)	
Heaton Fees Paid		Interest Paid	
Roraff Fees Paid		***TOTAL COMPENSATION PAID**	
M.S. 176.191 Paid		*Total Supplementary Benefits	
Other Fees Paid		**Total Medical Expenses Paid to Date**	
Costs & Disbursements Paid			

INSURER/SELF-INSURER/TPA	CLAIM REPRESENTATIVE NAME	
ADDRESS	PHONE NUMBER (include area code)	EXTENSION
CITY STATE ZIP CODE	DATE SERVED ON EMPLOYEE	DATE SERVED ON ATTORNEY

*Include attorney fees in these totals.

Distribution: Workers' Compensation Division, Employer, Employee, Insurer